

Cancer Family History Questionnaire

PERSONAL INFORMATION

Patient Name		Date of Birth	Age
Gender (M/F)	Today's Date (MM/DD/YY)	Health Care Provider	

Instructions: This is a screening tool for cancers that run in families. Please mark (Y) for those that apply to YOU and/or YOUR FAMILY. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family.

You and the following close blood relatives should be considered: You, Parents, Brothers, Sisters, Sons, Daughters, Grandparents, Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, First-Cousins, Great-Grandparents and Great-Grandchildren

YOU and YOUR FAMILY's Cancer History (Please be as thorough and accurate as possible)

CANCER	YOU Age of Diagnosis	PARENTS/SIBLINGS/ CHILDREN	Age of Diagnosis	RELATIVES on your MOTHER'S SIDE	Age of Diagnosis	RELATIVES on your FATHER'S SIDE	Age of Diagnosis
<input checked="" type="checkbox"/> Y <input type="checkbox"/> N Example: Breast Cancer	45	-----	-----	Aunt Cousin	45 61	Grandmother	53
<input type="checkbox"/> Y <input type="checkbox"/> N Breast cancer (Female or Male)							
<input type="checkbox"/> Y <input type="checkbox"/> N Ovarian cancer (Peritoneal/Fallopian tube)							
<input type="checkbox"/> Y <input type="checkbox"/> N Endometrial (Uterine) cancer							
<input type="checkbox"/> Y <input type="checkbox"/> N Colon/rectal cancer							
<input type="checkbox"/> Y <input type="checkbox"/> N 10 or more Lifetime Colon/ Rectal Polyps (Specify #)							
<input type="checkbox"/> Y <input type="checkbox"/> N Pancreatic cancer							
<input type="checkbox"/> Y <input type="checkbox"/> N Prostate cancer							
<input type="checkbox"/> Y <input type="checkbox"/> N Other Cancer(s) (Specify cancer type)	Among others, consider the following cancers: Melanoma, Pancreatic, Stomach (Gastric), Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid, Prostate						
<input type="checkbox"/> Y <input type="checkbox"/> N Are you of Ashkenazi Jewish descent?							
<input type="checkbox"/> Y <input type="checkbox"/> N Are you concerned about your personal and/or family history of cancer?							
<input type="checkbox"/> Y <input type="checkbox"/> N Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? (Please explain/include a copy of result if possible) If Yes, Who? _____ What gene(s)? _____ What was the result? _____							

BREAST CANCER RISK MODEL INFORMATION

Your current height (ft/in) _____ Your current weight (lbs) _____

Your menopausal status:

- Pre-menopausal
 Peri-menopausal (time before menopause marked by irregular cycles)
 Post-menopausal: Age of onset _____
 (permanent cessation of period for 12 months or longer)

Your age at time of first menstrual period _____

Your age at time of first live birth _____

Did you ever use Hormone Replacement Therapy? Yes No

If yes, type: Combined Estrogen only Progesterone only unknown

If yes, are you a: Current user: How many years ago did you start? _____
 Intend to use for _____ more years

Past user: How many years ago did you stop using? _____

Have you ever had a breast biopsy? Yes No

If yes, do you know your diagnosis? _____

Number of daughters _____ Number of sisters _____

Number of maternal aunts (mother's sisters) _____

Number of paternal aunts (father's sisters) _____

HEREDITARY CANCER RED FLAGS (complete with your healthcare provider)

Personal and/or family history of any one of the following

(check all that apply):

MULTIPLE: A combination of cancers on the same side of the family:

- 2 or more:** breast / ovarian / prostate / pancreatic cancer
 2 or more: colon/rectal / endometrial / ovarian / gastric / pancreatic / other (i.e., ureter/renal pelvis, biliary tract, small bowel, brain, sebaceous adenomas)
 2 or more: melanoma / pancreatic

YOUNG: Any 1 of the following at age **50 or younger:**

- Breast cancer Colon/rectal cancer Endometrial cancer

RARE: Any 1 of these rare presentations at **any age:**

- Ovarian cancer (Peritoneal/Fallopian tube)
 Breast: Male breast cancer or Triple negative breast cancer (ER-, PR-, HER2- Pathology)
 Colon/rectal cancer with abnormal MSI/IHC, or MSI high associated histology**
 Endometrial cancer with abnormal MSI/IHC
 10 or more colon/rectal polyps*

Certain ancestries such as Ashkenazi Jewish, may have greater risk for hereditary cancer syndromes

**Presence of tumor infiltrating lymphocytes, Crohn's-like lymphocytic reaction, mucinous/signet-ring differentiation, or medullary growth pattern *Adenomatous type
 Assessment criteria based on medical society guidelines. For medical society guidelines, go to MyriadPro.com

CANCER RISK ASSESSMENT REVIEW (To be completed after discussion with your healthcare provider)

Patient's Signature	Date
Health Care Provider's Signature	Date

Office Use Only	Patient offered hereditary cancer genetic testing? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> ACCEPTED <input type="checkbox"/> DECLINED
	If yes and accepted, which test? <input type="checkbox"/> BRACAnalysis® with Myriad myRisk® <input type="checkbox"/> Multisite 3 BRACAnalysis REFLEX to BRACAnalysis with Myriad myRisk <input type="checkbox"/> COLARIS®PLUS with Myriad myRisk <input type="checkbox"/> COLARIS AP®PLUS with Myriad myRisk <input type="checkbox"/> Single Site Testing <input type="checkbox"/> Myriad myRisk Update <input type="checkbox"/> Other: _____
	Follow-up appointment scheduled: <input type="checkbox"/> YES <input type="checkbox"/> NO Date of Next Appointment: _____